ASSIGNMENT OF PAYMENT

My attorney and/or the insurance carrier are hereby requested and authorized to pay direct to **Northshore Chiropractic Clinic,** any monies due on account, and same to be deducted from any settlement made on my behalf.

Further, I agree to pay **Northshore Chiropractic Clinic,** the difference, if any, between the total amount of my charges and the amount paid by the attorney and/or insurance carrier. It is further understood that I, undersigned, agree to pay **Northshore Chiropractic Clinic**, the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay the claim.

I hereby authorize **Northshore Chiropractic Clinic**, to release any records, information, or facts concerning my illness or injury and to administer whatever examination and treatment deemed necessary.

I hereby authorize my attorney and/or insurance carrier to release any and all records, information, or facts concerning my illness or injury necessary for payment to **Northshore Chiropractic Clinic.**

Dated at Mandeville, LA this _____ day of _____, 20_____.

Patient Signature:

_____

Witness Signature:

_____

Consent for Chiropractic Treatment and Acknowledgement of Receipt of Information

To the patient: Every type of health care is associated with some risks of a potential problem. Health care providers, including chiropractors, are required, by law to tell you the nature of your condition, the general nature of treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.

2) Disc herniations: Disc herniations that create pressure on the spinal nerve or cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscles or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.

4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

Consent

I hereby authorize and direct Northshore Chiropractic, together with associates and assistants of its choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays, and any additional procedures or services that may be deemed necessary and reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name_____Date_____Time_____

Signature of patient, parent, or guardian_____

Relationship to patient_____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

Signature of chiropractic physician_____Date_____Time_____

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information, including all of your clinical records, to other health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, your employer, your attorney, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you and provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, of other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.164.508(b)(5)(i)
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company might have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:

Northshore Chiropractic Clinic
1551 Girod St.
Mandeville, LA 70448-3729

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health information. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for 6 years from the date that your record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an account of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made by you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- Those disclosures for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPPA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come for treatment or by mail. If we make a change in our privacy terms the change will apply for all of the health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

David V. Mroski, DC
1551 Girod St.
Mandeville, LA 70448-3729
(985) 624-2971

Appointment Reminders and Health Care Information

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information. You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released you health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize you to use or disclose my health information in the manner described. I am also acknowledging that I have received a full copy of the Notice of Privacy Practices for Protected Health Information from Northshore Chiropractic Clinic.

_____ _____ _____

Printed Name Signature Date

May Release information to:_____ Patient offered copy_____

Patient Information and History Form

Required Personal Information Date _____ File # _____
Name _____ Home# _____ Mobile# _____
Address _____City/State/Zip _____
Age_____ Date of Birth _____ Sex _____ Marriage Status _____ Children _____
Occupation_____ Employer _____Work #_____
Spouse's Name _____ Occupation _____ Employer_____
Nearest Relative _____Phone #_____
Person Responsible for this Account _____ Referred By _____
Please describe the principle health problem for which you came to this office:

_____
_____
_____
When did symptoms first occur

_____
_____
List any other doctors seen for this problem

_____
_____
List diagnosis and type of treatment

_____
_____
Does this interfere with activities? Yes≅ No≅ How?

_____
Have you lost any days of work? Yes≅ No≅ Dates:

_____
Have you had similar symptoms or injuries before? Yes≅ No≅
If yes please explain _____
_____
_____

Insurance Information

≅ Auto Accident ≅ Worker's Compensation ≅ Health Insurance
≅ Medicare ≅ Personal Cash Payment ≅ Medicaid

Name of Company and Address_____
Social Security # _____ Claim # _____ Policy # _____
********** **For Office Use Only Below This Line** **********
MM EPO HMO PPO MC MG MK MP PI WC 1 6 7 8 9

Accident/Injury Information

Date of Accident _____Time_____ AM ≅ PM ≅ Police Report Made? Yes≅ No≅
Place/Location of accident

_____
Direction of impact: Struck from behind ≅ Right side ≅ Left side ≅ Front ≅
Your position at the time of accident: Driver ≅ Passenger ≅ Front LMR ≅ Back LMR≅
Description of accident